

Student Health Form

Please complete and return to the Student Health Center.

(Please Print in Ink)

Name _____
Last First MI

Home Address _____

City _____ State _____ Zip _____

Telephone Number (_____) _____ Student Cell Phone (_____) _____

Date of Birth _____ Male Female

Enrollment Status On-Campus Resident Off campus Commuter

Emergency Information

Name _____ Relationship _____

Telephone Number (_____) _____

Health Insurance *Please provide a front and back copy of insurance card.*

Insurance company name _____

Agreement / Policy number (include letters) _____ Group number _____

Name of insured _____ Relationship _____

Personal Medical History

Are you being treated for any medical condition? Yes No

Please specify: _____

Are you taking any medication? Yes No

Please specify: _____

Disease / Surgeries / Injuries _____

Have you ever been diagnosed with depression / anxiety / or other psychological illness? (Please explain) _____

Allergies

Are you allergic to *anything* - including prescription medications, over-the-counter medications, foods, insects, inhalants?

Please specify allergy and reaction. No known allergies

Allergic to _____

Reaction: _____

Physical Examination

This must be completed and signed by an MD / DO / PA-C / NP

(Please Print in Ink)

Student Name *(last, first, middle)* _____

Date of Examination _____ Age _____ Date of Birth _____ Sex _____

Blood Pressure _____ / _____ Pulse Rate _____ Height _____ Weight _____

Please include a separate sheet of paper to explain the status of any chronic medical or physical conditions.

	Normal	Remarks		Normal	Remarks
HEENT	<input type="checkbox"/>	_____	Genitourinary System	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	_____	Endocrine System	<input type="checkbox"/>	_____
Chest	<input type="checkbox"/>	_____	Nervous System	<input type="checkbox"/>	_____
Abdomen	<input type="checkbox"/>	_____	Seasonal Allergies	<input type="checkbox"/>	_____
Musculo-skeletal	<input type="checkbox"/>	_____	Depression / Anxiety	<input type="checkbox"/>	_____
Back / Spine	<input type="checkbox"/>	_____	Other Psychological Disorders	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	_____			

General Comments

Recommendations for physical activity

Do you have any recommendations regarding the care of this patient? _____

Is this patient now under treatment for any medical or emotional conditions? _____

Required for intercollegiate athletics/cheerleading: This student is cleared to participate in intercollegiate athletics/cheerleading.

Yes No

Signature of Clinician _____ **Date** _____ *MD / DO / PA-C / NP*

Printed Name _____

Address _____

City/Town _____ **State** _____ **Zip** _____

Phone Number _____

Medical Release Statement

By signing this, I affirm that all information in this document is correct and complete. I also agree to inform the student health center of any changes in my health or in the information on this form. I authorize the King's College health provider to begin appropriate treatment in the event of an illness or accident. Yes No

I will be responsible for all bills incurred that are not covered by my health insurance carrier. Yes No

I authorize release of relevant medical information or medical records to my parent/guardian upon request. Yes No

Student Signature _____ Date _____

**King's College
Immunization Verification**

Student Name (*last, first, middle*) _____

A. Required Immunizations

Dates must include month and year

MMR (Measles, Mumps, and Rubella) Two doses required

Dose 1 _____ given at age 12 to 15 months or later

Dose 2 _____ given at age 4 to 6 years or later and at least 1 month after first dose

Meningococcal A, C, Y, W-135

(One dose- required by PA law for all college students living in residence halls and to be considered by any college student who wishes to reduce the risk of disease.)

Dose1 _____

Meningitis Immunization Waiver

Note: All resident students must present verification of meningococcal vaccination prior to moving into any campus residence. If the student chooses not to be vaccinated, you must sign the **Meningitis Immunization Waiver** or you will not be allowed to move into a college owned residence.

I have read and understand the information provided me on the risks associated with meningococcal disease and the availability and effectiveness of the meningitis vaccine. I am voluntarily and intentionally refusing this immunization. I have read and signed this document with full knowledge of its significance.

Student Signature _____ Date _____

B. Suggested Immunizations

Dates must include month and year

Tetanus-diphtheria (Td) or **Tetanus, diphtheria and acellular pertussis** (Tdap)

Booster _____ within the last ten years

Hepatitis B (Three doses of vaccine)

Dose 1 _____

Dose 2 _____

Dose 3 _____

Varicella

Disease _____

Vaccine _____

Mantoux (Tuberculosis)

Date Given _____

Pos

Neg

Date Read _____